Agenda	Discussion	Action Item
1. Meeting to order – Ann Hale, co-chair	Reminded members in-person to also sign the sign-in sheets and members participating on phones to email attendance to AUC inbox	
2. Anti-trust statement: http://www.health.state.mn.us/auc/pdfs/antitrust.pdf	Must comply with anti-trust statement during meetings; please refer to statement on website if there are questions	
a. Introduction and welcome of Elise Westby, new Eligibility TAG co-chair	Ann H. welcomed the AUC Operations Committee and members introduced themselves. Members participating via teleconference/WebEx were asked to email their attendance to the AUC inbox.	
3. Companion Guide annual maintenance updates a. Claims DD TAG b. Eligibility TAG (and updates, discussion of reporting "2 digit and 4 digit PMAP codes") c. EOB/Remit TAG d. Medical Code TAG	Dave recognized new Eligibility TAG co-chair Elise Westby, who were not able to attend the meeting, and a. Sue Lee, Claims DD TAG co-chair reported that TAG discussed status of their organizations ICD-10 implementation. Most have started testing or working with CH and payers to begin testing. Another discussion topic was the November 5 workers' comp symposium and what TAG could do to help improve the process. Sue also reported that Lisa Wichterman, Department of Labor and Industry (DLI) stated that DLI was working with industry to develop some rules to address the following challenges identified at the symposium: 1) transparency and Payer IDs; 2) claim event number; and 3) attachment standards. DLI's will propose the new rules through their Workers' Comp Advisory Council. b. Pete – EOB/Remit met 1/22 and approved submission to CORE; submitted business scenario. Will meet next week to review: PMAP best practices to determine what changes might be needed as a result of the new four PMAP codes developed by DHS;	

	and to review and discuss the 835-HIX grace period notification best practice and decide if it should be a rule instead of a best practice. c. MCT – Medical Code meeting this Thursday; agenda have been sent to members. Last month entered all changes to companion guide. Very large issue with Autism; lots of code changes. Basic coding info – DHS is developing modifiers to some of the services. The intent is to be in compliance with the 2013 law and has been approved by CMS. Still open for additional information that might come back. Other issues with mental health development – has to be approved by Federal. Coding changes for the gambling addiction program; open up public health nurse update. Table current in companion guide. Collaborative – working with PH nurses gathering coding requirements with payers. Notice sent out same all recommendations are not the same. Brought to MH PH nurses as well as payers and providers in Minnesota. Will work with them. d. Eligibility TAG – Dave provided overview of PMAP, DISH payments received by several hospitals to level the playing field In order to file to receive DISH payments must have certain information available. A couple of years ago BP was developed for Medicaid enrollee data (270/271) and instructions in companion guide for remittance advice. Recently questions regarding additional details that could be available Exec met with DHS to look at information and handed off to appropriate TAG to look at it. Learned that primarily affects hospitals.	

	Mechanism AUC devised; behind the scene Medicare eligibility may change . Over a million recipients; 5,000 have eligibility type that will matter (makes) out of 5,000 less than l00 counts for the Medicare DISH. DHS feels small number that it affects and who should be responsible for TAG no action until further discussion between DHS and hospitals. Will report back to TAG. Joe – PMAP is not only MERC and hospital and reporting (all are retrospective; so if can identify claims on the backend, would be an alternative solution, depending on how old claim is. Has been a burning issue for about 10 years due to trying to identify commercial versus medical . Program is important ; payers are supplying information and encountering 4 digit could that need to be supplied when Could we push info forward without a lot of work? What is the best way to bring on enrollment file? Is place appropriate, can it handle it and is it compliance? Can payers provide? Two-digit TAG for almost two years looking at all of these components – perhaps can Point of clarification – something was submitted to CORE and had been resolved. Other states are having same issue. Andrea – 4-digit PMAP codes. The major programs are still 2-digit; the remaining two are eligibility. Some examples: MA – eligibility type says children 2-18; parent to dependent child; identify; does MA NM – state funded MA covers non-cititizes not eligible for	

	NM and CB – inforants between 275-285 poverty level Only matter on five codes. Bob- 2-digit has historically been sent; now eligibility type is now being sent. People were not aware they were getting these. Whether two digits or four digits, DHS should communicate we are sending this information (not sure what org is getting or how is it being sent). It is part of the 271 that DHS returns and is in a separate loop. Elig is not on 835 but 271. DHS is following enrollment file DHS sends to HP is where plans get info to send to providers. Wanted to understand if additional eligibility is needed in certain circumstances, s hould we modify the best practice to allow them to continue providing information. Was easier for HP to populate because they have that information and might be limited to the two-digit. Mary with significant no. of patients. Not limited to DISH and maybe simple of more informational that DHS can provide. Many meetings and a lot of work because it was found to have value for reporting. Makes sense to have DHS and Hospital Association. If you would like for someone from attendance to be in attendance. Information about TAG on website and also provided in AUC update.	
4. ACO data analytics updates	Relates to question AUC received about great amount discussion a Will attention be paid to any data flowing be	

	made standard. Did some relationship Health reform activity rather than an AUC issue. Background – State Innovation Model Test new ways of delivering and paying for health care. Meet the triple Aim Within SIM grant, number of goals accountable communities for health, Headed up by DHS in league with MDH to take models and apply to all payers within the system Support providers – Data analytics – slide 10 Gather data and improve performance. Key element – within SIM activity Two large advisory groups Community advisory trask force and Multi-payer alignment task force What are the data need by provider to improve performance and meet challenge of providing service in an effective way. How will data be transmitted and exchanged? Is there a standardized way? The parallel universe: what is needed and how do we get them standardized Operating in two phase – first pretty high level; principles and key findings, - (slide 12) Trying to determine what resources are available and how to make best of it. No one size fits all; has to work for everybody (Let's not reinvent the wheel). Reach out to new populations. Came up with no. of categories – Standardization will be needed: Timeframes System formatting Data files Some issues	

	Walked through report – AUC is interested in making connections as we move forward. Chair know need is patient attribution and risk mitigation. March 18 more discussion of ACO Data Analytics; will try to remain in contact and available; basically keeping the communication channels open. Mary – HCMC director of analytics – how do you look for standardization? Sometimes we may have expertise in what is being sent in the transaction versus what is not allowed. Perhaps can be helpful. These are open, public meetings. Will send PPT to Ops.	
5. Workers Compensation symposium follow-up (Department of Labor and Industry (DLI) draft proposal)	Dave MDH and DLI for last several years helping administer and enforce workers compensation and challenges. Natinwide about 100 represeting payers, providres a dCHs. Very well know nationalorganizaiton and vendors. Very helpful in discussing challenges and obstacles with workers compensation ebilling and crossover to Helped identify challenges and obstacles and determining solutions DLI has developed draft legislation Lot of opportunities to work with a variety of groups to DLI chose key problems – proposals are in addition to 62J First part effective 2016 – payers must place on their website CH, Payer ID (see slides) Payers or CH were rejecting claims because they didn't want Must identify what part of claim number on	

	claims Too many problems with attachments; did lots of research. Chose 275 because CH and payers could accept Contact Effective date for EFT, september 1, 2015, payer must provide PN, PC#, Must specify payment for each patient in bulk 3-11-15 meeitng at 2:30 p.m. Insurance federation have given thumbs up and willing to approve When approved by adivosry council wll be sent very soon? Usually hen approved by council; Hospitals support legislation. Moving paymet methodology to DRG Part of if transaction can be handled both ways, 250-300 carriers -	
6. Workers Compensation and ICD-10	Question regarding ICD-10 readiness for workers compensation…In MN our statutes has been updated that when federal mandate, MN WC will be effective. Are payers ready? I hope so. If reporting – can only presume they are and are waiting for feds to give green light. Sent out bulletin to remind everybody and especially WC when federal implementation is effective, so will Minnesota's	
7. ICD-10 outreach opportunities	Dave announced – many opportunities can be taken advantage of to reach out MDH – has annual rural health conference to Applied for a couple of different opportunities and was accepted for both. Pre-conference with navigators – walk through steps and get them to better place Setup stations and find someone who could ask question Find out where they are and give best info as possible	

	Reached out to Shelagh Tony and Ottomeyer – help staff stations Learning station – prepared 15-minute program and bell will ring – go to four areas Opportunity – first time June 29-30 CMS resource – will attend rural health conference (making connections within rural health community and Shelagh to find other venue to bring in this CMS resource. Talking to Ottomeyers' who have been as out Look for additional information – will be reporting back to the AUC and might be contacting you	
8. Implementation status check for Rx ePA mandate by 1/1/16	Slide 27 – Ann Foster under Medicare modernization act, Required under state law in 2011 About 10 years Current deadline 1/1/2016 – one-page companion guide recently adopted national Recent reports at nat'l state – two days ago, more that 150 pres each year requires 20% abandoned because process is too labor intensive; about 50% vendors are committed to EHR 22% EHR 60% of payers are prepared 2/3 – 70% of pharmacists Red requires common forms be available Oranges mandates like MN Laurie Darst and Shelagh – attended Laurie – NPCDP – hasn't gone through any federal rulemaking process or interim __NPRM process. Perhaps will happen in May. Some folks are utilizing now Possibility that rule will be issued by CMS.	

	Might be problematic; might be changes to standard that NCPDP. Ann researched EPIC – medical group side expert. NCPDP standard that EPIC 2014 release – can utilize through that version Step where transporter/sure script. Need to Some vendors have implemented or in the process of implementing the NCPDP standard. Mary – June 9 NPRM is posted, AUC can have on Ops agenda. Ann stated will be on agenda for remainder of the year. Worth everyone taking a look at it. May want to provide comments. Individual organization can use or submit their own. If MN view is valid would want to explain in comments to determine what response might be. Rather than have them move forward without knowing what's in place. Shelagh – may have had input from some folks in our Will provide comments if appropriate. If AUC comments in support if not controversial. Will share as soon as information is received. Ann – HP has selected vendor and are in final negotiations. Will be implementing prior to 1/1/16. Already do electronic prior authorization. Will be communicating with providers. Dave – Medica in process of working with vendor and are on track for 1/1/16. Shelagh - BCBS will be ready. PBM business Cover my Meds; directly to plan will set up web-based elements to enable providers to use. Obviously may need to modify if standards are out. Will be ready well before 1/1/16 Sue – Allina – upgrading to version in July and re currently testing and getting processes in	

	order. Laurie – Mayo moving forward (real interesting to see what lessons learned from people who are already doing this) seems to be a number of health plans who have implemented Tony – Ridgeview waiting to hear back from IT department to determine if PM system is capable. If vendor is not ready, looking for payer to have forms and have vendors embed it in Andrea – DHS will submit RFP to seek capability to Rx EPA. Mary – status checks will remain on agenda throughout the year Dave – MDH will contact states who have mandates to present to AUC	
9. Legislative update	Joe – Summary of legislative that will impact Deemed year of mental health; lot of legislation. Back treatment; state relying on Payment/access issues. Are being dealt with through various bills Undertone – address more of the rural concerns – workforce (more physicians in rural communityies and practitioners) Infectious disease, especially scare with ebola. Better response network in place for infectious disease that could come out of anywhere – funding and infrastructure Telemedicine – create more parity. Widely available to all payers and payments are similar to in-person. Rural patients don't have to travel back to city Payment reform – WC expect to come to resolution (heavy contact with Commissioner's office) will be committed to process to get inpatient rates settled and outpatient –	

	Medicaid rebasing – no new money (better or worse payments) Critical access hospitals will make a cost-basis Rich Ottomeyer – may have uncovered a doughnut (9th or 10th presentation) when we've mentioned assessment or risk assessment. How do we produce it for electronic information? Across the board medical providers, physical therapists, chiropractors. DRG shifts – 35 scenarios Any electronic – what is security level? How do you control data? Atta station two – has to be complete. Dave will follow-up with OHIT and give contact info to Rich O.	
10. Other Business		
Next Meeting: 2:00 p.m. – 4:00 p.m., June 9, 2015 (In-person & Teleconference/WebEx)		